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Emplacing India's "medicities"

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Abstract

Plans for 'medicities', announced in the Indian press from 2007 onwards, were to provide large scale 'one-stop-shops' of super-speciality medical services supplemented by diagnostics, education, research facilities, and other aspects of healthcare and lifestyle consumption. Placing this phenomenon within the recent domestic and global political economy of health, we then draw on recent research literatures on place and health to offer an analysis of the narration of these new healthcare places given in promotional texts from press media, official documents and marketing materials. We consider the implications of such analytic undertakings for the understanding of the evolving landscapes of contemporary health care in middle-income countries, and end with some reflections on the tensions now appearing in the medicity model.

Keywords: consumption; India; healthcare; neoliberal; place; private sector;

Introduction

> *the difference between a hospital and a medical city is as vast as the difference between a corner shop and a megastore. What you don't get at the shop you will be certain to get at the store* (Pandeya 2007)

A plethora of plans for "medicities" or "health cities" in different Indian states were announced in the press media in the period from 2007 onwards. They were to provide large scale "one-stop-shops" of super-speciality medical services supplemented by diagnostics and other aspects of healthcare and lifestyle consumption. In the words of an early advocate from a State Industries department, these were to be "a modern city within a city complete with technology and infrastructure facilities that compare with the best in the world" (The Times of India 2003).

How is the construction of new healthcare places such as these best understood? In this paper we seek to contextualise the medicity phenomenon within the recent domestic and global political economy of healthcare and to apply some key social science ideas about place, landscape, and global circuits to its analysis. We begin by presenting a brief history of the private hospital sector in India, followed by overviews of recent research literatures concerning conceptualisations of place, and the place-specific landscapes of private sector interventions in health care. We then draw on these to construct a critical reading of the promotional materials and related online press media coverage generated by the Indian medicity project. Findings are structured with reference to Gieryn's three defining and interacting features of place: material form, territorial location, and invested meaning. Through these features we explore the emplacement of the medicity both in relation to social practices and structures of contemporary neoliberalisation in India and in relation to global circuits and mobilities. Finally, we consider the implications of such analytic undertakings for the understanding of the evolving landscapes of contemporary health care in middle-income countries, and we end with some reflections on the tensions inherent in the medicity model.

Recent political economy of the private hospital in India

Described enthusiastically as "the most 'it' idea in the hospital business" (India Today 2010), the grand medicity projects enabling the further growth of the private healthcare sector were to be developed through private-public partnerships (PPP). Over 15 sites were proposed for initial projects in large cities across different states in India (Table 1).

Proposed site (city/area name)	**City position in state**
Gurgaon	Second largest city and industrial and financial centre of Haryana, 30km south of New Delhi
Pune	Second largest city in western state of Maharashtra
Nagpur	Second capital of Maharashtra
Hyderabad	Common capital of bifurcated Telangana and Andhra Pradesh
Lucknow	Capital of Uttar Pradesh

Chandigarh	Common capital for Punjab and Haryana
Ludhiana	Largest city in Punjab
Ahmedabad	Largest city in Gujarat
Thrissure	Eastern part of Kerala
Kochi	Most densely populated city and financial capital of Kerala
Kolkata	Capital of West Bengal
Jaipur	Capital and largest city of Rajasthan
Greater Noida	Census town in Uttar Pradesh
Kelambakkam	Suburb of Chennai in Tamil Nadu
Bangalore	Capital city of Karnataka

Table 1 Proposed sites for medicities in the first wave of publicity

Such developments can been seen as a latest phase in the rapid spread in market relationships in the health sector that has occurred in many low- and middle-income countries from the 1990s onwards (Mackintosh & Koivusalo. 2005). In India, their emergence was associated with the failures of underfunded state-provided health services to meet expectations, the accelerated spread of markets in the 1990s when many of the government restrictions on private investment were removed (Bloom et al. 2012), and an expanding middle class with disposable income. The private healthcare sector grew at an estimated compound annual turnover rate of 16% during that decade (PWC 2007:1).

At the same time under associated neoliberal policies there were attempts by government to reposition its role in the health sector. User fees were introduced in many states and government expenditure on health as percentage of GDP declined during that decade to less than 1% (Kanjilal & Mazumdar 2012) as against a global average of 6.5% (Patel 2014). Progress on public health issues was slow, with persistently high maternal and child mortality at the same time as a growing burden from non-communicable diseases, forecast to account for almost three quarters of all deaths in India by 2030 (Raban et al. 2012).

India had begun to experience a greatly increased commodification of healthcare through the activities of medical entrepreneurs and real estate developers. Twenty years previously almost all large healthcare institutions had been run either by the government or supported by private donations to be run as charitable hospitals. But there was a steady ascension of the private sector to the dominant position in the inpatient market during the last two decades, particularly in the most economically developed states (such as Gujarat, Maharashtra, Punjab and Karnataka) where only about a quarter of all hospitalized cases were registered in public hospitals by 2004 (Kanjilal & Mazumdar 2012).

Many small private hospitals had between five and 30 beds and were owned and run by doctors. However in growing cities such as Hyderabad where the metropolitan area alone has a population close to 6.5 million there was estimated to be only half of the required 25,000 hospital beds. This business opportunity caused a rapid growth of tertiary and super-speciality hospital provision in the commercial sector. This in turn has brought in corporate

houses, venture capital, and a process of mergers and acquisitions leading to corporatization of the market (Lefebvre 2008, 2009). Soon corporate listed companies like Apollo Hospitals, Fortis, Max, Escorts, Wockhardt, and Aditya Birla group were engaging in ambitious plans for expansion of their chains. In addition individual hospitals such as Escorts Heart Institute in New Delhi and their returnee specialist surgeons were making their reputation via the informal networks of medical travellers (Grace 2007), and the corporate chains had their eye on capturing a substantial share of this market (O'Brien 2014).

The variously named "medicity", "medical city" or "health city" emerged as part of India's social imaginary in this context. Conceptualised as encompassing perhaps 10 or 15 super-speciality and multi-speciality hospitals plus other complementary elements of the health care industry, it was presented as the pinnacle of modern India's "healthcare offer".

Researching and theorising place and private healthcare

There has been an important tradition of critical public health research on the evolution of the private sector in healthcare in India (e.g. Baru 1998), and private health markets (e.g. Bloom et al. 2012). Social and political scientists have also examined aspects of the global biotech industry (Sundar Rajan 2006) and medical migration and travel (Solomon 2011). But with the exception of geographer Bertrand Lefebvre writing on the growth of the corporate healthcare sector (Lefebvre 2008, 2009) such work on India has rarely drawn explicitly on ideas about the relationship between health and place. In the next paragraphs we consider insights from key contributions within the disciplines of sociology and geography to the study of healthcare places in the context of contemporary neoliberalisms.

The concept of place has been given somewhat erratic attention within sociology. Anthony Giddens recognized that places are made through human practices and institutions even as they help to make those practices and institutions (Giddens 1984). But in a key review in 2000 Thomas Gieryn drew attention to the invisibility of "place" in much subsequent sociology, except as a backdrop to events or a stand-in for clusters of other variables. He argued that place matters because, like time, it permeates and mediates social life.

For Gieryn it was clear that social processes such as difference, power, and inequality happen through the material forms that we design, build and use. Of the diverse 360-plus published papers to subsequently cite his review, only a few directly applied his bundle of three defining and interacting features of "place" –*material form, territorial location*, and *invested meaning* to the empirical study of healthcare places. However Humphrey's study of London's Harley Street as a place and an idea offers an elegant example of its useful application (Humphrey 2004).

More recently Daryl Martin and colleagues make the case for a distinctive sociology of healthcare architecture combining approaches and methods from the sociology of health and illness and science and technology studies. In line with Giddens, they suggest not only that contemporary healthcare buildings manifest design models developed for hotels, shopping malls and homes, that reflect "wider moves towards neoliberal forms of subjectivity, whereby patients are construed as consumers and responsibilised citizens" but

also that architecture plays a more active role in shaping and configuring such changes (Martin et al 2015 p 1018).

For geographers place has been a central concept. The sub-discipline of health geography, emergent from around the same time as Gieryn's work, set out to show that "places matter" with regard to health, disease and health care. Kearns and Moon identified three different approaches evident in that work at the time: studies grounded in the specifics of particular localities, studies employing multilevel modelling, and of most immediate interest here, a group of studies that considered the notion of "landscape" as not only literally defined localities in the manner of Gieryn, but also "a metaphor for the complex layerings of history, social structure and built environment that converge in particular places" (Kearns and Moon 2002: 611). It is this work that has emphasised the cultural importance of place and the intersection of the cultural and the politico-economic in the development of place-specific landscapes of private sector interventions in health care under health system restructuring. Examples of this research tradition include studies by Kearns and colleagues in of accident and medical clinics in shopping malls (Kearns and Barnett 1997) and of private hospital developments (Kearns et al. 2003); by Barnett and Brown (2006) of a corporate hospital chain; and by Hossler (2013) of the privatization of a US clinical campus. Hossler (2013) points out that hospitals as healthcare places have been of interest to medical geographers since the 1970s, but that the research on hospital services, marketing, and consumption, as well as community resistance to hospital closures, has largely been limited to four countries: England, New Zealand, Australia and Canada.

These brief summaries of key literature from two disciplines indicate some useful avenues for considering the manifestation and practice of neoliberalisms in contemporary healthcare in middle-income countries. Of particular relevance is the shared emphasis on the cultural and socio-economic importance of place and its reciprocal relationship to social norms and to the practices of power. A further significant body of literature is that pertaining to the rapid increase in medical travel, and top destination countries such as India, Thailand, Malaysia, Singapore, the Philippines and Mexico (Connell, 2006; Ormand 2013;Turner, 2007). Medical travel although still dominated by local cross-border movements by individual users paying privately for care abroad, or journeys made by diasporic patients returning "home" for medical treatment (Connell 2013), is increasingly inserted in a global market place, one catering both for the individual "medical tourist" and also offering corporate packages and aiming to attract contracts with states and insurers abroad (Lunt et al 2011; Turner 2007).

This literature reveals an industry driven by government agencies, public–private partnerships, private hospital associations, airlines, hotel chains, investors and private equity funds, and medical brokerage (Connell 2013; Lunt et al 2011; Turner 2007). Connell argues that contemporary medical tourism industry can be understood as a function of the growing privatisation and commodification of health care, where the ability to pay has become the key to obtaining medical care (Connell 2013). Billing places as glamorous global health destinations or "health theme parks" reflects these broader trends in post-industrial societies, and the emergence of the patient "consumer" with a sense of entitlement to physical and biological perfection (Connell 2015).

For Gieryn, a “place” has a geographical location, it is “ a unique spot in the universe” (Gieryn 2000:464). But he was also aware that “the struggle between those who produce places for profit and those who consume it in their daily rounds is played out against a global struggle *among* places for the wherewithal to grow.” (p470). The existence of an increasingly globalised healthcare market with mobilities of investment finance, trade in services, and mobile users of healthcare requires us to take due consideration of the relationship between the unique spot on which a healthcare facility is physically constructed and regional and global social processes of power, competition and difference.

There is a vast array of work in both disciplines on the new global economy, but it is perhaps Saskia Sassen’s work on cities that offers most insight, as it highlights the new mobilities of people and money and the notion of global circuits that become terrritorialized or sited at diverse regional, national and global scales (Sassen 2002, 2009). For Sassen recent privatization, deregulation, the opening up of national economies to foreign firms and the growing participation of national economic actors in global markets “has provided a context in which the key articulators now include not only national states but also firms and markets whose global operations are facilitated by new policies and cross-border standards produced by willing or not-so-willing states” (Sassen 2002 p14). With these comments in mind we set out in the next sections to emplace the medicity in relation to social practices and structures of contemporary neoliberal India, but also to be concerned with how and in what ways their production may reflect the partial unbundling of the national and the territorialisation of global circuits of capital and digital technologies.

Materials and methods

> *How do geographic locations, material forms, and the cultural conjurings of them intersect with social practices and structures, norms and values, power and inequality, difference and distinction?* (Gieryn 2000: p 467)

Gieryn suggests that there were at least two ways to answer this question: the first to explore how places come into being, the second to find out what places accomplish (Gieryn 2000). This case study focuses primarily on the first approach but in later sections we venture some suggestions related to the second. The materials and methods available for such explorations may vary according to context. Kearns & Barnett (1997), for example, proposed that an interpretation of health care sector reforms in western nations can be undertaken not only through an assessment of policy and outcomes, but also through a reading of the texts they and their promotors produce. These texts, they suggested, comprise the various means by which messages are sold - and could include both policy documents and the specific ways that health care enterprises project themselves. Following this line of thinking, we draw for our analysis on English-language texts produced by and about a variety of Indian medicity projects. These texts include official documents and consultancy reports, direct marketing materials including facility websites and promotional videos, and the considerable digital coverage given to the medicities in the dailies and specialist press media.

Historically the readership of English dailies in India has consisted of the English-speaking elites of India, including policymakers and the educated urban middle-class (Dutta & Sen

2014).The analysis of outputs through which a concept such as the medicity is advertised and marketed in this news press is particularly useful for developing an understanding of its cultural conjuring. Bourdieu and Wacquant (2000) have highlighted how the logic of neoliberalism is articulated, disseminated and embedded in the social psyche through perpetual repetition of neoliberal ideas in the news media. Ursula Rao has described how economic liberalization in the 1990s contributed to the rapid commercialization of the Indian news business" (Rao 2010, p. 717). So while the national press is now virtually independent of political financing and often highly critical of politicians, journalists find themselves under immense pressure to appease corporate customers, who lobby for feel-good journalism and advertorials aimed at the middle-class consumer (Rao 2010). There was also a disproportionate expansion of print and online niche market business news, with at least four national daily English-language economic newspapers as well as regional and national supplements on business news in virtually all major newspapers and dozens of national business news magazines, almost all with online counterparts (Chakravartty & Schiller 2010).

We (SFM, RB and EP) located materials through Internet searches using Google, Altavista India and India Times engines in 2009 and updated in 2011 and 2013. A further follow up search was conducted via Google from March-May 2014 supplemented by ongoing Google alerts for the key words *medicity* and *health city*. These terms were used interchangeably in the promotional material. For simplicity we employ the original term: "medicity", which remains a more accurate representation of the curative focus of these developments.

We identified just over 240 relevant texts. These were read / watched and sections of material was systematically categorised by SFM under Gieryn's three defining and interacting features of "place" –*material form, territorial location*, and *invested meaning,* with additional coding for *global interactions and mobilities* as a fourth, cross-cutting theme. Data bits within each thematic was then examined and further coded and categorized. The goal was to note not only information provided and claims made about the intended physical configuration, location and financing of the proposed medicities but also the particular images and metaphors and persuasions used in promotional materials, and the underlying discourses that reveal evidence of the cultural economy of health care (Kearns et al. 2003). Emerging ideas were tested against other material within the theme and discussed within the team. In the following sections the themes are used as the framing device for our reading of the place-construction of the Indian medicity. Direct quotes are used to support our interpretation of the findings, and these are discussed with reference to relevant supporting literature.

Findings

<u>"Like lanes of sari shops": the (proposed) material form of the medicity</u>

The core feature of the medicity was the agglomeration economy model: the bringing together on the same location of a number of high end "superspeciality" hospitals on one site, that would between them offer an array of cardiac surgery, joint replacements, liver transplant, nephrology and renal dialysis, stem cell transplants, cosmetic and reconstructive surgery and so on, supplemented by other complementary commercial activities from

shared waste management to implant warehouses, in order to rationalise and share costs of production. It also appealed to an Indian tradition of geographical concentration of traders. In the words of one industry advocate, a modern equivalent of “the lanes of sari shops in Calcutta”.

Relatively new in India, the super-speciality hospital had gained traction because it initially seemed to satisfy the needs of commercial healthcare delivery. Its business case revolved around the savings that could be made from rapid throughput (often surgery-driven), high volume and reduced human resources, equipment, and infrastructure. Clinical activities were not the only source of income. Hospitals chains could generate new revenue streams through “hospotels” (Gunnam 2008) - combining hospital and a hotel, gifts retail, 24-hour pharmacies and eating places including fast food outlets.

The consultancy firms and other advocates of the medicity took this approach far beyond the individual hospital and its satellite services to the development of ”an eco-system” a “one-stop-shop”, and a “self-sustaining township” and the “Med-polis” (Technopak 2009) complete with medical colleges and conference centres, R&D facilities, shopping malls, hotels, serviced apartments, plus staff accommodation for a 24/7 workforce.

The mainstream Indian press media of this period, well disposed to hyperbole and the production of “infotainment”, proved willing mouthpieces for the envisioning of this brave new medical-world, as indicated in Figure 1. The utopian project of the medicity as indicated here had something to meet every need. Indeed grand scale has been an integral part of the selling of this imaginary. Escorts Heart Institute and Fortis Healthcare, for example, are reported promising to generate over 10,000 medical graduates each year from each of ten proposed medicities “in the pipeline”(Pandeya 2007), a wildly exaggerated proposal probably designed in part to appeal to middle class families for whom a child in the medical profession was still a highly desirable achievement (Wilson 2011).

..the healthcare city may be spread over 800 acres with an estimated investment of Rs 20,000 crore[i]. The proposed health city will have 100 hospitals with a total capacity of 50,000 beds.

Besides hospitals, the healthcare city will have medical colleges, nursing institutions, para-medical training institutes, technical training centres and hospital management schools. The hospitals will have super-special facilities like referrals and laboratories for investigations. ….

It will also have provision for hotels and guest-houses to accommodate about 25,000 people visiting along with patients. The city will have a shopping mall and a cineplex, too.

There will be an international building for foreign medical tourists that will house interpreter services, travel services, representative offices of foreign consulates and other government offices.

The building will also have a helipad on its roof for air-lifting emergency patients. … There will be other common facilities like waste management, power plant, electronic laboratories, ayurvedic centre and naturo-therapy unit. On the hospital campus, pharmaceutical and other companies will set up warehouses….

The health city is projected to provide employment opportunities to almost three lakh[i] people

Extract from 2008 press article "A healthy model" in *The Sunday Tribune – Spectrum* (Kumar 2008)

i. three lakh = 300,000

Figure 1. Press description of the proposed Chandigarh medicity

The metaphor of the city was also extended to include accompanying vaccine and biotechnology "parks":

> [In Chennai] *the medicity will ..commence with a National medical science park, … The park will also have a symbiotic relationship with the proposed 1,000- bed multi-specialty 'bio-hospital', ..*

> *The proposed medicinal science park would be a hub for R&D in regenerative medicine and in advanced scientific areas such as nano-technology and genetic engineering. According to Dr Cherian, "this facility will be exclusively dedicated to basic and applied clinical research, development and commercialisation of technology for use of both preventive and curative healthcare*."
> (extract from eHEALTH in Hospital News 2009)

Thus the medicity offered up the prospect of multifunctional patients who would not only seek out and consume private healthcare, they would buy in the insurance market to facilitate such access, and in an effort to keep the costs they incurred under control could provide themselves to the on-site resident biotech industries and private medical institutes as material and opportunities for research and development in exchange for drugs or treatment technologies.

Gieryn echoed Habraken in reminding us that social processes (difference, power, inequality, collective action) happen through the material forms that we design, build, use, and protest (Gieryn 2000). The "symbiotic relationships" between treatment services and commercial Research & Development (R&D) on medicity sites were reported in the India press media without critique but they represent a troubling potential for the corporate exploitation of financially insecure families. Here too the medicity as manifestation of the territorialisation of global circuits of capital and the opening up to foreign firms is apparent. The extensive restructuring along global lines of trials for pharmaceutical and biomedical products has been analysed in some depth by other scholars (Petryna 2006; Sunder Rajan 2010; Sundar Rajan 2006). Outsourcing of clinical trials to specialized research service providers who secure the most cost effective access to "clinical labour" has resulted in relocation of the actual conduct of clinical trials in genetically diverse India, as well as in its competitors, China & Eastern Europe (Petryna 2006).

The federal state supported an Indian role in these global operations and to provide the necessary conditions to make this happen. In 2005 regulations were changed to liberalise conduct of clinical trials there (Nair 2015). The availability of Indian bodies for global R&D was actively promoted by India Brand Equity (IBEF). IBEF was created by the Department of Commerce "to promote and create international awareness of the Made in India label in markets overseas" and "bring live the India business story" (IBEF 2013). IBEF declared the business case to contract research organizations without equivocation: "India offers both a huge patient pool, favourable regulatory environment and cost advantage for conducting clinical trials" (IBEF 2013).

The medicity configuration would offer the potential of a huge shift in the balance of influences from public to private sector, a shift going far beyond the provision of surgery In the past research and training had been largely the preserve of the Indian public sector hospitals but, in the words of one journalist commentator:

> "medical cities could change the way that medical education and research and development is conducted in India, taking it from public to private to corporate" (Pandeya 2007)

These “city parks” for R&D and attached training institutions therefore manifested ambition for a key change not only in the landscape of private sector interventions in Indian health care, but also for a further shrinkage in the public sector role.

The (proposed) territorial locations for the Indian Medicities

For Gieryn, a “place” has a geographical location, it is “ a unique spot in the universe” (Gieryn 2000 p 464). It proves useful to examine reporting on the proposed geographical locations for the medicities as this reveals the powers behind these new places, the intended consumer base, and the extent to which political and business elites at state level were keen to collaborate on these new projects.

Locations to exploit internal markets with good return: “India Inc. finds wealth in health”

Many of the initial announcements related to greenfield medicity projects as listed in table 1 were for locations in the metropolitan cities (1 million+ populations). However such investments could prove an expensive option. Unless subsidised, real estate could reportedly constitute about 40 per cent of the cost of a new hospital project (Jayakumar 2009). Some subsequent territorial locations earmarked for medicity developments aimed at a potentially profitable domestic market of healthcare users residing in less costly medium-sized cities. Government subsidies offered to the private sector for setting up hospitals in these Tier 2 and Tier 3 cities also included a five-year “tax holiday” (PWC 2012).

In the final turn of an apparently virtuous circle for place entrepreneurs, a Tier-2 city designation as an “emerging healthcare hub” allowed real estate agencies to market it as having the sufficient “social infrastructure” (a ranking calculated on the number of hospitals, shopping malls and cinemas in the city) to be an ideal retirement relocation destination for India’s growing “senior” middle-class population (Mukerji 2013).

The marketing described medicities as “public-private partnerships”, but state subsidy of private industry would be more accurate. The driving organisations tended to be industry-led concerns such as the Confederation of Indian Industry or those parts of government concerned with economic growth and infrastructure development, tourism and foreign direct investment (FDI). One early idea from the State Ministry of Health in Kerala involved a link up with the Cuban Health department to construct a medicity with stem cell and biotechnology research (Rajiv 2008), but this degree of Ministry of Health leadership seems an exception. In the event the lead on the Kerala project was quickly taken over by “Infrastructures Kerala” an organisation established by the State Government to increase the pace of industrial infrastructure development. Inkel was itself a public-private enterprise in which the Government held 26 percent (see http://www.inkel.in). Handing the project over was deemed attractive to the health department as it reduced the financial burden for the Government, although the Ministry of Health was still expected to hand over some 100 acres of land to the construction of the project (Pillai 2011). Such an “investor friendly medical policy” was considered a crucial contribution from local government officials in order to attract good investors in most states (*Times of India* 2008). Reports of disputes were rare but usually centred on land allocation. *The Tribune* for example cited concerns in the Union Terrritory of Chandigarh over the decision that 45 acres of “prime land” in an IT park near Manimajra

were to be given away to the medicity investors at 10% of market value (Thukral 2008). However, the aligning of politicians with the healthcare industry generally went without comment in the Indian English language press.

The interaction of territorial locations with global circuits

> *HYDERABAD: At least 12 new hospitals are set to spring up in the city's Shamshabad-Hi-Tec City stretch over the next few years. Apart from local names, the list also includes international brands that are driving into the city in large numbers hoping to cash in on not just the rising demand for specialised healthcare but also on Hyderabad's world-class airport that has positioned the city as a medical tourism destination.* (Times of India 2011)

With an eye to international clients and to favourable business conditions, many Indian medicities were to be near international airports and within Special Economic Zones (SEZ). SEZ were introduced in India in 2000 to attract FDI, increase exports and accelerate economic growth in India (Technopak 2009).

The medicity at Nagpur, for example, was proposed by The Maharashtra Airport Development Company (MADC), a Special Purpose Company constituted in 2002 by the state government. Its proposals caught the interest of the US Embassy, as this cable extract demonstrates:

> *The Maharashtra state government also hopes to create a "health city" in the SEZ. It envisages that Indian and foreign health care providers will establish state-of-the-art clinics to attract foreign medical tourists. R.C. Sinha, vice-chairman and managing director of MADC, claimed that the cost of treatment in India was roughly one-tenth that of countries like the U.S. and believed that this huge cost differential and the modern, sophisticated medical facilities available in the health city would draw in foreign medical tourists.* (US Embassy 2006)

Special economic zones are a means by which global circuits of capital and trade become – indeed are invited to become - territorialised. They are new kinds of places in which normal domestic rules of practice on ownership, duties and taxes are suspended to favour external trade and investment. The commodification of healthcare allows it to be listed alongside "various export-oriented units like I.T. industries, gems and jewellery, garments, electronic goods, pharmaceuticals, processed foods" (Zilla Parishad Nagpur n.d.) as just one more business proposition for engaging in a global economy.

The growth potential of medical tourism (medical travel associated with visits to cultural and leisure opportunities) was highlighted in 2002 by the Confederation of Indian Industry and its international management consultants McKinsey in *Healthcare in India: The Road Ahead* (McKinsey and Company 2002). India saw its market advantage as the combination of well-trained doctors, many of whom specialised in the US, UK or Australia, combined with considerably lower costs of labour. It became the subject of considerable optimism for its potential as a foreign exchange earner and a source of stable profits from patients with high

purchasing power. The Ministry of Tourism suggested the average medical tourist in India will spend more than US $7000 per visit as against the $3000 of the ordinary tourist (Bhat 2015, p 21).

Under the World Trade Organization General Agreement on Trade in Services (GATS) aimed at reducing barriers and creating a favourable climate for trade in services, India has scheduled one explicit commitment within the four health sub-sectors, that for hospital services (Bhat 2015). In 2003 then Finance Minister Jaswant Singh called for the country to become a "global health destination" and urged measures such as improvements in airport infrastructure to facilitate this. Ministry of Tourism brochures advertise centres of healthcare excellence and from 2005 medical visas were available to potential patients and their companions (Chinai & Goswami 2007). Press coverage indicates that politicians in power of every hue were in favour of such medicity developments. Even the Communist Party of India in West Bengal supported the development of a medicity as part of a tourism policy, guided by a strategy paper prepared by another international management consultancy Ernst & Young (Lefebvre 2009; The Hindu 2008).

It should be noted that extra revenue earned by medical tourism is not taxed to support public health (Bhat 2015). Indeed, private hospitals treating foreign patients receive benefits such as lower import duties and enhanced rate of depreciation for life -saving medical equipment. The National Health Policy 2002 declared that the rendering of health services on payment in foreign exchange was to be deemed "exports" and therefore eligible for the fiscal incentives extended to export earnings. The industry also uses a pool of medical professionals who trained in public hospitals, and one estimate suggests that this alone results in indirect subsidy of some 4-5000 million rupees per year (Sengupta & Nandy 2005 p 1158).

Initially many patients have been Non-resident Indians (NRIs) or patients from neighbouring states such as Bangladesh, Afghanistan and Nepal, but the long-term stated aim is to secure agreements with US insurance companies. Such was the commitment to suspend normal domestic rules of practice in national border control to facilitate the requirements global trade that MADC's managing director even "*envisaged creating a customs and immigration 'envelope' of the SEZ and international airport to allow medical tourists to come for treatment without obtaining a visa".* (US Embassy 2006)

Thus the medicity can be understood as a territorial manifestation of activities in a number of global circuits (Sassen 2007). These include those of international management consultancies, of trade in services, and migratory patients, and also of international finance. The "Commercial presence" mode 3 of GATS for the health sub-sector involves the establishment of hospitals, clinics, diagnostic and treatment centres and nursing homes. While India did not make a formal commitment here, it has become increasingly open to FDI by allowing equity up 100 per cent. Total FDI inflows into India in hospitals and diagnostic sector for the period 2000–11 were estimated to be $1.00 billion (Bhat 2015:22).

For their part, Indian corporates were not only expanding into Tier 2 and 3 cities in India, they were also eyeing up the increasingly lucrative African middle-class market (IMTJ 2013) and exploring opportunities to bring themselves geographically nearer to the huge USA

consumer base. Celebrity Indian heart surgeon and entrepreneur Devi Shetty is best known for the "lean" Fordist production-line surgery implemented in his hospital chain, Narayana Health (NH), lauded by Harvard Business School (Khanna & Biljani 2011) and the Wall Street Journal (Anand 2009). He failed to bring his model to Mexico in partnership with a Californian not-for-profit, but sited his latest "health city" in the off-shore tax haven of the Cayman Islands (Goozner 2016). A partnership between NH, Ascension Health a large US based Catholic non-profit, and the Cayman government, the project currently only offers heart surgery and joint replacement (the start-up staples of the medicity) but is aiming to increase from 200 to 2000 beds over time. Digital technology circuits for tele-diagnosis and tele-monitoring technologies also enable cross-global efficiencies. Shetty's hospitals claim to be set to "leverage different time zones" so that his doctors in the Cayman Islands can monitor post-operative patients in his Indian hospitals via video feed during the night (Pearl 2014).

Invested meaning

Places can be said to be doubly constructed - most are built and they are also "interpreted narrated, perceived, felt, understood and imagined" (Gieryn 2000). As with urban transformation and gentrification projects in other countries, symbolic systems legitimised and sold the Indian medicity through familiar neoliberal rationales of "progress, competitiveness, excitement" (Zukin 2010).

Early media publicity conjured India's proposed new medicities as a mechanism for generation and redistribution of healthcare resources for wider benefit, either through improved general provision or by "offloading the excess burden" of super speciality care from the state government. But as Gieryn points out, advantaged groups and individuals seek to put distance between themselves and the less advantaged (Gieryn 2000 p472), and as Kearns and Barnett (1997) have described in the context of western nations, the market-based ideology of health reforms in recent years has constructed healthcare as a product in the consumers world, rather than a service.

Publicity material for the medicities offers idealised images of settlements like space stations, hospitals like five-star hotels with columns and soaring ceilings, barely peopled at all and displays of high technology surgery. Simultaneously, images of tailored personalised care depict a contented child in dialogue with an avuncular man in a medical coat, or a smiling senior in a wheelchair surrounded by a "family" of healthcare staff. Such symbolic constructions are a part of the "place-making" that add a sense of exclusivity. There is no place for India's poor or visibly sick in these imaginaries, and it is here that the "public" element of the PPP becomes rather obviously unstuck.

Reputation is paramount in the private sector with so many competitors, information asymmetry, and poor regulation. Almost all the private hospitals claim guiding principles of providing affordable medical services to patients with care, compassion and commitment. The medicities' tag-lines work to a fairly standard recipe: "The Medical City. Healthcare that cares"; "Medanta the Medicity. Dedicated to Life" providing, in Kearns and Barnett's words "a semantic veneer... covering the reality of commercial transactions" (1999 p 207).

Trust is further evoked by private hospitals using two main strategies. The first, appealing to the domestic market, is the tying of brand reputation to the images of entrepreneurial doctors who become the institutional figureheads. The most successful of these, enthusiastically assisted by journalists, manage in the public imagination to span those difficult and easily conflicting terrains of philanthropic healer, extraordinarily-gifted surgeon, celebrity media personality and capable business person. Eminent cardiac surgeons such as Naresh Trehan and Devi Shetty were particularly popular, providing the right mix of dedication and glamour to the medicity project.

Medicities may be monuments to discretionary consumption but the hospitals' highly effective publicity machines also fed the press media with regular heart-warming stories that emphasised technical prowess and which appeared to imply that medicity services were open to all regardless of income:

> *NEW DELHI: A Haryana farmer's quick thinking helped save the life and limb of his three-year-old boy, whose arm was severed from the chest wall while playing in the farm land. In an intricate, 10-hour surgery, which doctors said hasn't been earlier reported in medical literature, the limb was replanted at Medanta Medicity, Gurgaon.*
> *The father of a three-year-old boy, whose right arm was cut off from the chest wall in a thresher accident, said he never thought the severed hand could be rejoined.*
> *'I took him to a nearby dispensary on a motorcycle because there was no ambulance. When we reached the local dispensary, they immediately referred us to another hospital where the first aid was done and the doctors preserved the severed arm in an ice-bag before sending us to Medanta Medicity for surgery,' said the father, Arvind Sangwan* (Nandan Jha 2014).

The second reputation-builder is the medicity's link to an aspirational India that is "world class". International linkages and enhanced reputation derived particularly from the USA – achieved through the external qualifications and work experience of returning doctors and through institutional affiliations to Johns Hopkins Medicine International (Apollo Hospitals), Harvard Medical International (Wockhardt), the American Heart Foundation and so on. Eligibility criteria for bidders for land for medicity projects often specified "an international tie-up" as well as existing experience running a large hospital and accreditation with the National Accreditation Board for Hospitals and the National Accreditation Board of Laboratories (Express Healthcare News Bureau 2008).

"Quality of care" is often used by the private sector as its differentiating feature, and many of these hospitals also applied for Joint Commission International accreditation once established. Such accreditation gives security to Indian middle and upper-class users, but in the case of the SEZ medicities it is also intended to open the way for contracts for international patients from the USA. There are also attempts in parallel to establish a distinctively "Indian" face to give the projects a distinctive market niche. Naresh Trehan's "New Era Medicine" for example reportedly aims to "combine modern medicine, Ayurveda, homeopathy and Chinese medicine" (Pandeya 2007).

This recurrent portrayal within audio-visual and written texts of the private sector hospital businesses as being those capable of "excellence" set by "global" (western) standards, also leads to the further legitimation of their presence within "health care talk" by policy makers, politicians and the public at large in turn, serving to increasingly sanction the desirability of the material construction of medicities. There is thus a recursive link between the ideological and material landscapes of private health care (Kearns et al. 2003).

Discussion

Our analysis of the texts produced by the promoters of Indian medicities suggests that these places can be understood as a product of the deregulation and privatisation that opened up the domestic healthcare sector to speculative transactions. In line with political economy notions of place-making (Gieryn 2000; Lefebvre 1991; Lefebvre 2009) we can see that the proposed medicities assumed specific material forms, territorial locations, and cultural meanings in order to facilitate the pursuit of profit -through production of goods, services and knowledge in a healthcare industry, and through investments in land and construction. The complicity of the domestic political class with such objectives is clear, following the double political imperatives of achieving urban economic growth in a competitive global environment and in parallel to be seen to be "doing something" about health without incurring major debts.

Beyond India, our analytic undertaking has some resonance for the understanding of the evolving landscapes of contemporary health care in other middle-income countries. For of course India has not been alone in such actions. The built environment boom can be seen elsewhere in other continents, with projects for the growing middle and wealthy classes constructing gated communities, office campuses, shopping malls, hotels and entertainment venues. It is to this expanded leisure sector that healthcare consumption is a recent addition.

The format of the Indian medicity was in many respects an attempt to replicate efforts elsewhere. Similar marketing-speak of "one-stop shops" can be seen across many sites that compete in the medical tourism sphere, for example, Yanhee hospital in Bangkok (see http://yanhee.net/about-us/overview). The destination branding metaphor of the medical city has been used outside India, particularly by small states wishing to diversify their economy. From 2001 the city-state of Singapore was marketed as a Biomedical City, a centre for biomedical and biotechnological activities (Cyranoski, 2001). Beyond US models, the biggest inspiration and competitor for the Indian medicities - but with considerably more coordinated planning and far greater levels of investment – is the Dubai Health Care City. A creation of Dubai Development and Investment Authority (Henderson 2007), and designed to attract the vast numbers of Middle Eastern medical tourists to stay within the Middle East rather than travel to Asia, it too contains speciality hospitals, clinics, accident and emergency sites, research units and foreign medical schools including joint venture agreements with the US Mayo Clinic and Harvard Medical School (Crone, 2008; Davis 2004).

Our focus for the substantive part of this article has been on the *idea* of the medicity, as represented through promotional materials. The conjuring of that idea has, we argued, served an ideological purpose, helping to legitimise the interests of the private healthcare

industry in India. But what do we know of the extent of its physical realization and the likely future of medicity developments?

> *Medical cities are grown over decades, not built in years. One medicity can't offer the best care for a wide range of specialities and services at the same time*"
> Naresh Trehan, president, Indian Healthcare Federation, quoted in Pandeya (2007)

The reality seems that without the huge investment possible in oil-rich Dubai, medicity developments are not easy to coordinate and required long gestation periods and they are costly. In India costs have to be borne by investors and users, without the help from foundations and grants that enabled USA institutions like the Mayo Clinic to develop its non-profit teaching hospital model (Bhat 2015). Hospitals in Tier 2 towns have mostly been funded by bank loans at high interest rates of 13-14% (PWC 2012). And while cancer care services, for example, may be - in the cynical words of one Deloitte India analyst - a "brilliant niche gap", the reality is that "single speciality businesses can only grow so much" and there are constraints on how such cancer care can be extended to smaller towns as returns on investment become poor (Singh 2012).

Super-specialities proved to have an inherent problem of high-end expensive technologies impacting on their profitability:

> *One area of concern we have seen now is that tertiary hospitals are by their nature asset heavy, now people are talking about the returns on their capital investment… We compete with the best in the world so capital investment is high, but prices for medical treatment are a fraction and that creates lop-sidedness in returns in investment, and in replicability*. (Bansal of KPMG 2013)

Thus the private sector service providers are coming under pressure from the business investors they courted. An essence of the global nature of financial mobility is that profits made at exit or intermediate points do not necessarily stay in India, nor are they necessarily reinvested there. Even Devi Shetty's famously "frugal" Narayana Health (NH), found itself under scrutiny. In 2013 Hong Kong-based private equity firms J P Morgan and Pinebridge that had invested some $100 million in a 25% stake in the company were reported to be looking to exit at a valuation that NH was nowhere close to achieving. As NH's Chief Executive explained to the *Economic Times*, NH's profit margin after tax was just around 8% "in healthcare you can't make the kind of returns they seem to want" (Ganguly 2013).

The issue of affordability to the user is evident both for India's poor and for the target middle-class users. As part of PPP arrangements, private hospitals free patient treatment to around 25% of outpatient department users and 10% of inpatient beds (Goverment of Delhi 2007). In practice municipal corporations and state governments have great difficulty holding their private sector partners to these commitments (TNN 2013; Goverment of Delhi 2007). Some hospitals set up philanthropic machinery to identify deserving cases and find them sponsorship from the business community. But even when some poor families can then access complex operations, the realities of follow up care and drugs are often far beyond their means (Aljazeera 2014).

Recently, concerns about endemic over-testing and over-treatment in the private healthcare sector have been voiced by the World Bank (Kalra 2014). While seldom reported in the commercialised press, reports on social media complained of "hidden costs" of patient and donor assessment, follow up care and extra treatment for complications that went far beyond the original "package deal" that the users believed they had been offered (Mouthshut.com n.d.). For the domestic target group of urban middle class Indians the rising costs of private healthcare are highly problematic. Investors consider group insurance schemes to be loss making (Ravikumar 2014). In India about 76% of total health expenditure is out of pocket and inpatient treatment is the cause of impoverishment of, quite literally, millions of households (Berman et al. 2010).

As the issue of degree of profitability has become more pressing some insiders like Devi Shetty now sees multi-speciality hospitals as the future along with overseas expansion, other private sector groups aim to avoid the full costs of construction by moving into brownfield investments (Thakur 2015), taking over management of existing hospitals, or building new wings. International consultants who had heralded the medicities have also moved on and with equal enthusiasm now suggest that IVF chains, dialysis, day care centres and diabetes, all "inherently asset light and very much like retail healthcare models", are more "investment friendly"(PWC 2012). A greater emphasis on diagnostics fits the anticipated future growth in the health insurance market. It may be that, unless a considerable expansion in the volume of medical tourists to India occurs, the grand project of the Indian medicity will succumb to its internal contradictions, ultimately unable to compete in the markets for which it was conceived.

Concluding comments

We set out to provide a reading of the medicity through the texts that announced its presence and then have sustained and elaborated it subsequently. This analysis has been heavily reliant on material generated by the "upstream forces" driving the creation of the medicities, and also by the professional practices of place-experts such as architectural firms, real estate agents and healthcare industry consultancy firms. Those materials have proved to be a generous source for analysis of the imaginary they aimed to create. The dimensions of location, material form and invested meaning has proved a useful way into the development of a critical understand of these new healthcare places. Such analyses are particularly important as healthcare and related services become a growing activity in the landscape of economic development in middle-income countries, yet public health needs continue to be considerable and public health infrastructures are seldom adequate to meet them. Critical accounts such as that presented here can help us to understand how neoliberalisms work in specific contexts. They can illuminate healthcare's role in an ideological as well as territorial landscape, and raise important questions about what role it plays in the reduction or recreation of social inequalities.

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